Letters to the editor

REGARDING OBJECTIVITY OF PSYCHIATRIC DIAGNOSES

DEAR EDITOR:

Dr. Ronald Pies's commentary in the October issue of *Psychiatry 2007* addresses an important issue [Pies R. How objective are psychiatric diagnoses? Guess again. *Psychiatry* 2007;4(10):18–22]. I have shared his concern that the stigmatization of psychiatrists and psychiatric patients is not helped by the frequent off-handed derision of the value of our diagnoses. And I too believe that much of this is coming from within our profession. Just today, a psychiatric colleague of the psychoanalytic persuasion explained to me that he thought our diagnoses are not as objective as those in the rest of medicine because "there is only one common psychiatric diagnosis where we actually know the etiology: PTSD." Of course, I couldn't agree that diagnostic objectivity is directly related to understanding the pathophysiology.

Unfortunately, though, Dr. Pies's commentary is not persuasive. The one piece of research that Dr. Pies cites to support his argument involves two psychiatrists using the Structured Clinic Interview for DSM-III-R with the same patients and achieving an impressively high interrater reliability for diagnosis. But structured clinical interviews come into use because they entail adequate interrater reliability! Hence his argument is essentially circular.

I was pleased and surprised by reading of the studies that show unimpressive interrater reliability for many nonpsychiatric illnesses. But, to make our case, there needs to be something more robust supporting a psychiatrist's day-to-day diagnostic consistency.

With regards,

Bennett Cohen, MD
Brooklyn, New York

AUTHOR RESPONSE

I appreciate Dr. Cohen's thoughtful reading of my editorial and the opportunity to clarify some aspects of my argument. Essentially, I argue that when properly carried out, psychiatric diagnostic procedures can yield agreement between observers ("interrater reliability") comparable to that obtained in several other medical specialties. (As Michael First, MD, has pointed out, "reliability" is properly predicated of diagnostic procedures, not diagnoses).[1] I further argue that, to the extent our diagnostic procedures produce good inter-rater reliability (high kappa scores) and to the extent that they entail careful empirical observation, psychiatric diagnosis partakes of "objectivity." My commentary touched only briefly on the more complicated issue of *validity* in psychiatric diagnosis—an aspect of objectivity I will address in a follow-up article.

Dr. Cohen finds that my argument is essentially "circular" because the study I cited[2] utilized the Structured Clinic Interview for *Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised*. Dr. Cohen opines that "structured clinical interviews come into use because they entail adequate interrater reliability…" implying (as I understand Dr. Cohen) that this somehow stacks the deck in favor of producing high rates of agreement between observers who utilize structured interviews. In my view, however, a full understanding of structured clinical interviews does not support this conclusion.

Instruments such as the SCID merely ensure that questions astute clinicians usually ask ("Are you hearing any unusual voices in your head?" "Are you feeling blue or sad?" etc.) are asked in a standardized way and without unintentional omission. Structured interviews do not preordain high levels of interrater agreement, though they may facilitate reliability. The actual "kappa" derived from two structured interviews of the same patient is never known in advance. Indeed, the outcome depends crucially on factors such as the training of the observers and their ability to detect nonverbal cues. As Nassir Ghaemi, MD, puts it, "Structured interviews give us the *possibility* of reliability, which then needs to be *demonstrated* between interviewers, but [structured interviews] do not simply ensure reliability between any and all interviewers."[3] [italics added].

To be sure, as Dr. Ghaemi notes, "…it is indeed circular logic to define [an] illness as one with a declining course and then to use course data to *validate* it."(italics added).[4] But interrater reliability is not meant to carry the burden of *validating* a diagnosis. It is, at most, a prelude to validation. Before we can go out into the field and validate the "reality" of a putative disease, we must first agree on what signs and symptoms define the ideal or prototype of the disease.[4]

Of course, interrater reliability among psychiatric clinicians is not always good, particularly when researchers apply DSM-based

criteria to diagnoses proffered by clinicians who may choose *not* to use DSM criteria.[3] Reliability of psychiatric diagnostic procedures may also drop when *nonclinicians* are doing the "observing," as in door-to-door epidemiologic studies.[5] With regard to "naturalistic" data, however, there is reason to be more optimistic. For example, in one study,[6] the reliability of diagnostic procedures by psychiatric residents in the emergency room was assessed by comparing their diagnoses with the inpatient discharge diagnoses of the same patients [*N*=190]. In both settings, diagnoses were based on DSM-III-R criteria, but structured diagnostic instruments were not used. There was moderate to excellent concordance for major depression, schizophrenic disorders, bipolar disorder, and substance abuse/dependence disorders, with kappa values ranging from 0.64 for major depression to 0.87 for substance abuse and dependence disorders.

Finally, I heartily concur with Dr. Cohen on the need for removing the stigma associated with psychiatric patients, their diagnoses, and their clinicians. I believe this process begins by making the case that psychiatric diagnosis, properly performed, can be as "objective" as diagnosis in other medical specialties.

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With regards,

Ronald Pies, MD
Professor of Psychiatry, SUNY Upstate Medical University, Syracuse, New York; and Clinical Professor of Psychiatry, Tufts USM, Boston, Massachusetts

LETTERS TO THE EDITOR SUBMISSIONS

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